



**A S S C I D**  
australian society of special care in dentistry

## **Submission to the Productivity Commission**

### **Inquiry into Introducing Competition and Informed User Choice into Human Services**

The ANZASND (Australia and New Zealand Academy for Special Needs Dentistry) and ASSCID (Australian Society for Special Care in Dentistry) are the two lead organisations in Australia representing dental professionals and others interested in oral health of people with special needs. We are jointly providing a submission to the Productivity Commission Inquiry into introducing Competition and Informed User Choice into Human Services. We will address some of the ‘REQUEST FOR INFORMATION’ related to the oral health of people with special needs referred to as “people with physical and intellectual disability, or medical or psychiatric conditions, that increase their risk of oral health problems or increase the complexity of oral health care” in Australia’s National Oral Health Plan 2004–2013 (1) and “People with additional and/or specialised health care needs (people living with mental illness, people with physical, intellectual and developmental disabilities, people with complex medical needs, and frail older people)” Australia’s National Oral Health Plan 2015-2024. (2) In this submission, we will refer to people with special needs and specify each subgroup as needed.

#### *REQUEST FOR INFORMATION*

*The Commission is seeking participants’ views on what constitutes improved human services. Do the concepts of quality, equity, efficiency, responsiveness and accountability cover the most important attributes of human services? If these are the most important attributes, how should they be measured or assessed?*

The concepts of quality, equity, efficiency, responsiveness and accountability cover important attributes of human services. However, application of these concepts may be challenging due to the heterogeneity of the population of people with special needs. Unlike the general population, people with special needs depend on their carers for their daily oral hygiene care and dental appointments. Those with communication problems (people with intellectual disability and cognitive impairment) may not be able to express need or assess the quality of care provided/received. In a South Australian study of adults with physical and intellectual disabilities, just over 50% communicated non-verbally or had little or no effective

communication. (3) It may also be difficult for their proxies (family/non-family carers/managers) to identify need and assess quality of care on their behalf. (3,4)

Limited workforce in Special Needs Dentistry is a barrier to efficiency and a high staff turnover in Aged Care and Disability Sector creates problems in responsiveness and accountability of services.

Inquiry into Dental Services for Older South Australians in 2010 (5) provided compelling evidence about the poor oral health status of older people, reported programs targeting the oral health of older people (will be discussed later) that have shown to be beneficial, but with limitations of uncertain funding arrangements, and made several recommendations. The ANZASND and ASSCID provided a submission to the Inquiry into adult dental services in 2013 (6) highlighting concerns specific to people with special needs- access to appropriate service provider, physical access, access to dental treatment general anaesthesia and the need for undergraduate and postgraduate training and continuing professional development. However, there is not much evidence of improved services.

To assess quality and improvement (or any change) in any service, baseline data is needed. Apart from several reports on oral health of older adults by Chalmers, (7-10) other cross-sectional studies are limited to people with physical and intellectual disabilities in South Australia (4,11,12) and people with HIV. (13,14) Freeman et al. (15) reported altered the oral health profile among people with HIV in South Australia with a retrospective analysis of patient case notes in electronic and handwritten formats.

Considering the multiple challenges in data collection for people with special needs (16), measurements or assessments for this group would need to be modified (simplified). The need for inclusion of carers and proxy reports should be considered. Measurement and assessments should include not just the direct costs associated with people with special needs, but indirect costs associated with their family and non-family carers like time off work can result in significant costs to the affected and economy at large.

Retrospective research should be supported and conducted on already available data collected at public/teaching hospitals for the growth of research with the ultimate aim of improving the oral health related quality of life of people with special needs. Electronic dental records provide unique opportunities for large epidemiologic research, currently lacking for this heterogeneous group.

Attributes could be measured by:

**Quality**

Oral health status at initial consult and recall visit

Oral health status at general anaesthesia and recall visit

Oral health related quality of life as reported by the individual or their proxy before and after a course of care

**Equity**

Waiting periods for initial consult or general anaesthesia for people with special needs compared to general population

## **Efficiency**

Number of people who receive care over a period of time in the dental surgery, theatre or residential aged care facilities (RACF)

## **Accountability and responsiveness**

Number of wasted appointments: 'failed to attend', no consent, non-compliance to pre-operative medications/instructions

## *REQUEST FOR INFORMATION*

*The Commission is seeking participants' views on which human services have the greatest scope for improved outcomes from the increased application of competition, contestability and user choice. Where possible, this should be supported by evidence from performance indicators and other information to show the extent to which:*

- *current and expected future outcomes — measured in terms of service quality, efficiency, equity, accountability and responsiveness — are below best practice*
- *competition, contestability and user choice do not exist under current policy settings, or are not as effective as they could be in meeting the goals of quality, equity, efficiency, accountability and responsiveness.*

*The Commission welcomes participants' views on how best to improve performance data and information in the human services sector.*

The Commission has taken a range of factors that will identify the services that are best suited to the increased application of competition, contestability and informed user choice, perhaps more so for the general population than people with special needs.

It is thought that competition will drive down prices, but this can be difficult for consumers (and proxies- family/non-family carers/managers) to assess quality. There is often a disconnect between the carers (paid) who provide the oral health care and diet, and the family/financial trustee who pay the dental bills. There is often a huge surprise when it is realised that the cost of treating poor oral health is very high, and suggestions that perhaps 'the dentists' are the problem, and are over charging. There is also little recognition that of all the health care areas, dentistry has far higher costs than most other providers. When providing mobile/portable service, the costs are higher again. The 'cheap' service is sometimes perceived as the better one, without recognition of the difference in the quality of what is provided.

Situations vary around the country. In Melbourne, a number of providers provide competition. However, some of the 'cheaper' providers are more interested in accreditation compliance via an annual check-up of residents. Their models work on volume and they will not go out to a facility to see less than a minimum or around 12 residents. This leads to the facility putting pressure on residents/families to change to this provider to make up numbers. The provider does provide some treatment, but then doesn't do follow-up/recall through the year. These providers 'cherry pick' patients to treat, and usually employ general dentists with very little mentoring or experience in the area. They also have a high turnover of dental staff. Difficult cases are referred elsewhere to people with more experience either publically or privately.

More expensive models will go and see smaller numbers of residents in a facility (or private home) at a time, and provide recalls throughout the year. These services are more preventatively focused which is a better model. Given the well documented poor oral health status of the frail elderly population (and people with special needs in general), many residents needing more frequent recalls than annually.

Accreditation is 'consumer driven' and responds to complaints, which means that although the oral and dental accreditation standard 'to maintain oral health' is rarely if ever complied with, there are no consequences to providers if there are no complaints.

*How best to improve performance data and information in the human services sector*

### **Aged Care**

Currently, residential aged care facilities (RACF) make contractual arrangements with private providers and designate a particular dental service for all residents. However, residents/families should have access to the range of choices available, and should have their own choice to see someone else if they want to. This has been the case in Medicine for many years, where residents are free to choose any GP they want to see, as long as they are willing to visit the RACF.

### **Disability**

In the National Disability Insurance Scheme (NDIS), dental professionals should be recognised as an important service provider and oral health care should be clearly included in the 'Plan of supports' for people with disabilities.

### **REQUEST FOR INFORMATION**

*Participants are invited to submit case studies of where policy settings have applied the principles of competition, contestability and user choice to the provision of a specific human service. Such case studies could describe an existing example or past policy trial in Australia or overseas. Participants should include information on the:*

- *pathway taken to achieve the reform*
- *effectiveness of the policy in achieving best-practice outcomes for quality, equity, efficiency, responsiveness and accountability*
- *applicability of the case study to the provision of human services in Australia if it is an overseas example.*

In the Hunter New England Local Health District, Resi-DENTAL Care Program is based on primary care principles that provide support with the implementation of the Commonwealth endorsed education and training package Better Oral Health in Residential Aged Care for carers and residents. It involves collaboration with private dental practitioners to coordinate and support the provision of dental care in RACFs using portable dental equipment, thus bringing regular dental services to the resident, overcoming access to services and transportation issues and reducing the need for residents seeking public dental care. Given the success to date with this program, this model of care could be adapted in other states.

Several projects in South Australia like Southern Aged Community Care Program and Northern Aged Care Dental Project provide oral health assessments to many but fail to provide the timely dental treatment needed.

The Medicare Chronic Disease Dental Scheme (CDDS) was in effect between 2007 and 2012. The scheme enabled people with chronic and complex conditions to be referred by their general medical practitioner to a private dentist to receive a comprehensive range of Medicare funded dental care up to \$4,250 (over a two-year period). However, it failed to provide quality and equitable oral health services for people with special needs as this scheme did not cover any treatment carried out in public hospitals, where most people with special needs (mostly on Disability Support Pension) are likely to attend.

As a follow-up of Special Olympics (SO) athletes post oral health screenings at the National Special Olympics Games in Adelaide 2010, AP enquired parents/carers of SO athletes (with Down syndrome and chronic conditions like diabetes) if they had participated in the CDDS. Interestingly, parents/carers had used it for themselves but not their care recipients and when one did, received an unexpected response that CDDS was available “only for people who sit in the dental chair”.

Supported Residential Facility (SRF) Dental Program established in 2004 in South Australia continues to offer dental treatment to all residents of licenced pension-only SRFs. People living in SRFs tend to have complex and diverse needs with many having a history of chronic homelessness. About 60% of SRF residents receive dental treatment through a multidisciplinary approach involving SRF residents, SRF Managers and care staff, external support agency staff, and public and private dental professionals.

A South Australian pilot study (4) evaluated a work-place dental intervention for employees with disabilities by measuring changes in self-rated oral health, dental behaviours and oral health-related quality of life (OHRQol). Referrals were arranged as needed to public dental clinics. At six months, self-rated oral health improved and there were significant reductions in the prevalence of oral health impact on quality of life indicating that enabling urgent referral for treatment and regular oral health education can improve OHRQol and self-rated oral health among employees with disabilities.

Similar multidisciplinary approach and group interventions could be expanded to other workplaces, community houses or day options for people with special needs.

## *REQUEST FOR INFORMATION*

*The Commission is seeking information on which human services have these characteristics:*

- *service recipients are willing and able to make decisions on their own behalf and, if not, another party could do so in the best interest of the recipient*
- *user-oriented, timely and accurate information to compare services and providers can be made available to users so they are able to exercise informed choice or, if not, this could be cost-effectively addressed*
- *service recipients (or their decision makers) have sufficient expertise to compare alternative services and providers or, if not, this barrier could be overcome*
- *outcomes experienced by a service recipient and their family and friends in past transactions can inform which service and provider they choose in the future.*

Many people with special needs (people with intellectual disability and cognitive impairment) may not have the capacity to make decisions on their own behalf and, if not, depend on ‘person responsible’ do so in the best interest of the recipient. Obtaining consent for dental treatment may not be too difficult if there are no problems within the family members. If family members do not want to be involved ‘person responsible’ needs to be confirmed. However, the ‘person responsible’ varies in each state, some include paid carers while others do not. In some cases ‘person responsible’ is an officer from the Office of Public Advocate (OPA), who may not have even met the person for whom the decision is being made.

People with intellectual disability and cognitive impairment may not have the capacity to exercise ‘informed choice’. NDIS encourages participants are given every opportunity to make their own decisions and exercise choice and control, but will include families and carers in discussions recognising their essential roles in supporting them. Therefore, families and carers should have adequate knowledge to be able to make ‘healthy choices’ for their care recipients in their best interest. However, very few carers in Disability and RACFs receive training in oral care to equip them to provide appropriate care and make appropriate decisions.

Peer support and word of mouth can be powerful resources in sharing information about experiences and choice of providers.

## *REQUEST FOR INFORMATION*

For specific human services, the Commission is seeking information on the nature of service transactions based on these characteristics:

- *the nature of the relationship between the service user and the provider*
- *whether the service is used on a one-off, emergency or ongoing basis*
- *whether the service can be provided remotely*

Building a relationship between the user and the provider is extremely important in Special Needs Dentistry. The success of treatment depends on the rapport built and the trusting relationship between the patient, the accompanying person and the dental assistant.

People with special needs don't always cope well with new clinics and providers each visit. Therefore, care should be taken to ensure continuity of care with the same provider in a familiar environment for better outcomes.

Dental services need care and regular follow-up. Some consultations and advice can be provided remotely, if it involves opinions in treatment planning. However, direct care will be needed if behaviour management is needed in addition to the technical skills.

Oral health services in Australia primarily operate on a fixed-chair model, where patients travel to a dental clinic to receive dental care. This model lacks the capacity and flexibility to address the needs of people who have difficulty accessing dental clinics due to physical (frailty, bed-bound) and sometimes even behavioural barriers (severe intellectual disability or psychiatric condition). These issues represent an inequity in access to dental care in the current system for people with such special needs.

### *REQUEST FOR INFORMATION*

*The Commission is seeking information on the supply characteristics of specific human services including:*

- economies of scale and scope — in terms of costs and service quality — that may be lost by having a larger number of competing providers*
- the potential for service provision to be made more contestable because there is capability beyond an existing provider that could pose a credible threat to underperformance*
- whether there are barriers to providers responding to change, or new suppliers entering the market, that limit the scope for increased competition, contestability and user choice or, if they do, what could be done to address this*
- technological change that is making competition and user choice more viable*
- factors affecting the nature and location of demand, such as geographic dispersion of users, the distribution of demand among different types of users, particularly disadvantaged and vulnerable users, and anticipated future changes in demand.*

There are currently only 15 practising registered specialists in Special Needs Dentistry (SND), with still fewer dentists providing care for people with physical and intellectual disabilities and the frail elderly. So in terms of supply characteristics, there is rather more concern about the limited workforce and growing needs.

The threat to underperformance is due lack of training in undergraduate dental curriculum and minimal exposure of dental students to the management of people with special needs.

In NSW, Hunter New England (HNE) Health has funding to provide mobile equipment and support for private dentists but the funding is limited so there are select private providers and select RACFs. When the funding level hits its max, which it has, there are RCFs excluded and private dentists unable to access the equipment. It is a similar situation in South Australia, with the Nursing home care program developed as a collaborative partnership between South Australian Dental Service Australian Dental Association (SA

Branch) and private dental practitioners. These are fabulous initiatives but can create barriers to new adequately trained SND specialists entering the market, as personally experienced by one of the authors (AP). Residents referred to the Special Needs Unit, Adelaide Dental Hospital by the participating private dentists were managed by AP. Ironically, funding restrictions limited AP to provide services at RACFs, which would have been more cost-effective- saving a lot of time and inconvenience for staff and the frail elderly, some of whom had to be transported via ambulance.

Availability of portable dental equipment and patient demand has led to a growth of mobile dentistry.

Given the changing demographics of the aging Australian population (increasingly more dentate) together aging of people with developmental disabilities and increase in dementia (and early onset dementia) the needs are going to be more challenging over time, nationally.

### *REQUEST FOR INFORMATION*

*For specific human services, the Commission is seeking information on:*

- *the regulatory arrangements and other initiatives that governments would have to modify or establish as part of their stewardship role, including to inform users about alternative services and providers, maintain service quality, protect consumers (especially disadvantaged or vulnerable users) from being exploited, and to fine-tune policies in response to any problems that emerge*

Australian Dental Association, ANZASND and ASSCID could provide information on appropriately trained and adequately equipped service providers to users via consumer support and advocacy groups.

### **Summary**

If the objective of this inquiry is to develop policy options to improve service provision, then the first steps would be to create an environment for healthy competition. This needs support for the few SND specialists in practice, academia and research; undergraduate and post graduate training in SND via scholarships; continuing professional development to produce adequately skilled service providers and research capacity to allow innovative strategies appropriate for people with special needs to be evaluated rigorously and continually improved. Government schemes should not be restrictive to private or public only as a multidisciplinary approach is necessary to provide optimal service for people with special needs.

Thank you for the opportunity to participate in this inquiry.

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